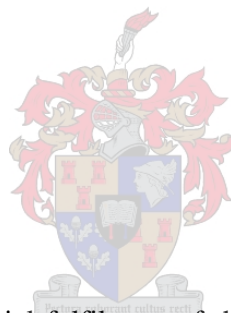


AN ASSESSMENT OF VOLUNTARY COUNSELLING AND TESTING/ HIV  
TESTING AND COUNSELLING SERVICES AT HEALTH FACILITIES IN  
SOUTH AFRICA

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An assignment presented in partial fulfilment of the requirements for the degree of  
Master of Philosophy (HIV/ AIDS Management) at Stellenbosch University

Study leader: Mr Burt Davis

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**Declaration**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

22 February 2010

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## **Summary**

This study assesses the quality of Voluntary Counselling and Testing or HIV Counselling and Testing (VCT/HCT) services among antenatal clients/patients at three health facilities in the Tshwane Region (Pretoria), as a service rendered for the prevention of mother to child transmission (PMTCT). It also examines the experiences of those who render this type of a service- lay counsellors at these health facilities.

While the survey results show a remarkably high level of access to VCT/HCT amongst pregnant women, it could be proven that the quality of services they get are not as satisfactory as expected. A total of 150 clients/ patients, and 15 lay counsellors were invited to participate in the survey. At the end of the survey period, which ran from 21 to 25 September 2009, it was found that a total of 150 clients/ patients, and a total of 15 lay counsellors responded by completing the survey. This represents a return of 100%.

## **Opsomming**

Hierdie studie assesseer die gehalte Vrywillige Voorligting- of MIV-voorligtingdienste (VCT/HCT) onder voorgeboorte-kliënte/-pasiënte by drie gesondheidsfasiliteite in die Tshwane area (Pretoria), as diens wat gelewer word ter voorkoming van moeder tot kind oordraging (PMTCT). Die studie ondersoek ook die ervarings van diegene wat hierdie tipe diens lewer – lekevoorligters binne hierdie gesondheidsfasiliteite.

Waar die studie ‘n merkwaardige hoë mate van toeganklikheid tot dié VCT/HCT onder swanger vroue aantoon, kan daar insgelyks bewys word dat die gehalte dienste wat hulle ontvang, nie so bevredigend is as wat verwag word nie. ‘n Totaal van 150 kliënte/pasiënte en 15 lekevoorligters is genooi om aan die opname deel te hê. Teen die einde van die opnametydperk, wat van 21 tot 25 September 2009 gestrek het, is bevind dat ‘n totaal van 150 kliënte/pasiënte en ‘n totaal van 15 lekevoorligters gereageer het deur aan die opname deel te neem. Dit verteenwoordig ‘n rendement van 100%.

# **1                    Introduction**

HIV and AIDS is one of the most important challenges facing South Africa today. The S.A. government has made the fight against this disease one of its top priorities. Knowledge of HIV status is critical to both prevention and treatment. The implementation of VCT services within a legal and human rights framework is a key intervention towards the realisation of the continuum of care.

National Strategic Plan (2007- 2011)

According to the '3 by 5' millennium goals, SA government is one of the countries which made a commitment that 3 million people who are eligible for antiretroviral treatment (ARVs) will be able to access it by 2005.

WHO (2004)

Health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support, however, at the same time, when HIV counselling and testing is implemented, equal efforts must be made to ensure that a support social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients which includes the following:

- Community preparedness and social mobilization
- Adequate resources and infrastructure
- Health care provider training
- A strong monitoring and evaluation system.

WHO & UNAIDS (2007)

However, one of the key challenges the S.A. government is experiencing in order to meet the expansion of such services including VCT uptake, is the lack of skilled health workers, ranging from specialized physicians, nurses, etc.

VCT services seek to ensure that people who test HIV negative are encouraged and motivated to maintain their negative status and those who test HIV positive are supported in living healthy lives through positive health.

WHO (2002)

HIV and AIDS Counselling is increasingly recognised by national programmes as the gateway to prevention, care, treatment and support interventions. The more people learn about HIV and AIDS, the better able they are to prevent transmission and to protect themselves from opportunistic infections. If they test negative, they can take measures to protect themselves and their families from getting infected.

WHO (2002)

As people become better informed, stigma and discrimination decline, making it easier for others to determine their status and thus break the chain of transmission.

(WHO 2004)

Community assessment is useful for building on existing services rather than duplicating them, knowing the responses of local organizations to the idea of introducing VCT/ HCT services, and compiling a list of referral centres for care and support services. Community assessment comprises the following:

- Deciding the target groups for VCT/ HCT services (high- risk and general population) and to calculate prevalence rates of HIV infection to prioritise allocation of resources for activities.
- Study the knowledge and attitudes of the community by listening surveys, observation of education sessions, and field- based research.
- Estimating level of risk among potential clients. These include gender- related power relations that affect negotiation of safer sexual relations, economic pressure resulting in commercial sexual activity, relations between young women and older men, and cultural practices contributing to high HIV prevalence rates. If the risk factors are high in the general population, routine
- risk assessment is necessary. If risks are high in certain sub- groups in the population, specialized outreach services may be suitable.
- Charting the existing HIV/ STI- related services: This involves collecting information by interviewing staff of local organizations/ health facilities and this can be used for mapping existing HIV/ STI related services, community needs, and gaps in services.

UNAIDS (2000)



Health care training and ongoing supervision is an investment. A redistribution of health worker responsibilities (task- shifting) in health facilities may help to overcome chronic staff shortages in some settings. This may entail identifying appropriately skilled lay counsellors who can receive training and remuneration to carry out VCT activities under the supervision of health care professionals with more specialised expertise.

UNAIDS (2004)

Evian (2000) cites the fact that HIV infection and AIDS lead to ill- health and often to emotional, psychological and social problems and these problems can also cause severe difficulties with relationships. It is therefore, important for people who are providing HIV counselling to do it very well from the onset.

The empowerment of women in the prevention of the spread of HIV and AIDS is critical, therefore, if VCT/ HCT services are strongly supported in the community they can be implemented successfully.

UNAIDS supports the notion by S.A. National Department of Health that their prevention strategy though VCT, they are able to estimate on HIV prevalence which is generated through blood tests on a sample of the women who visit antenatal clinics provided by the public health care system. During October every year HIV tests are done on blood taken from a representative sample of all women who visit public clinics for the first time in their current pregnancy, and they are asked if they wish to participate in the HIV tests and it is very rare that women decline to give blood for this purpose. Once the blood is taken, and the testing is done, there is no way for tracing the sample back to the women who gave blood. Therefore, the strengths of this method is that the HIV test in itself is very reliable and that the response rate is close to 100%, meaning that all of the sampled women in clinics do indeed provide the necessary information to generate an estimate.

Strand et al (2005)

In industrialized world, a number of European countries have introduced provider-initiated HIV testing and counselling in the context of pre-natal care. Provider-initiated HIV testing and counselling appears to have resulted in considerable increases in testing uptake in the United States, United Kingdom, Hong Kong, Singapore, Norway and Canada, where the majority of clients ( 4/5 or more in most studies) agreed to be tested. Concerned by persistent late diagnoses of HIV infection and a high proportion of people with HIV who are unaware of their HIV status, and in light of evidence that people who are aware of their HIV status reduce risk behaviours, the United States Centres for Disease Control and Prevention to issue revised guidelines recommending ‘HIV screening’ for all persons aged 13- 64 years attending health facilities in the US.  
(WHO & UNAIDS (2007))

VCT/ HCT can only be successful if all target groups in the community are more involved, therefore, if more support is available, the stronger the incentive will be for staff and clients/ patients to test for HIV and be open about results- just as it happens with cancer.  
Jackson (2002)

## **1.1 Research Objectives**

The objectives of this research paper will be to:

- determine if HIV counselling services in health facilities are of the required standard and quality
- establish whether the public opinion in SA among respondents who have been exposed to HIV counselling services have easy access to health facilities
- determine if lay counsellors are adequately trained for the work that they do
- ultimately lay a foundation for the improvement of HIV counselling services in health facilities to strengthen health care system.

## **2. HIV Counselling: A South African Perspective**

In 2004, the SA government introduced VCT services as part of the strategy to reduce the increasing spread of HIV transmission. These services were rolled out to more than 4,172 facilities country wide and many of these services were established in already existing health facilities.

HIV and AIDS & STIs Cluster: National Department of Health (2008)

In order to achieve HIV counselling goals, it is important to make sure that counselling sessions are easily accessible and information is provided during sessions, namely: pre- test counselling, post- test counselling and ongoing counselling. In public health

facilities, the pre- test education sessions are typically conducted in a group information session, followed by a short individual counselling session. It is also important that the following sessions take place as each leads to the other.

### **2.1 Group Information: Pre- Test Counselling**

A health care worker should conduct a general group information session on general health, HIV and AIDS related issues for all clients including pregnant women and clients for tuberculosis (TB), and other illnesses, and this should happen on a daily basis. A group information session should include the following key components

beneficial to the client, as appropriate to the circumstances:

- Information about HIV acquisition and transmission.
- Information about effective prevention measures, including consistent and correct use of condoms, partner education and other options.
- Emphasis on the importance and advantages of early testing to facilitate diagnosis, positive living and healthy lifestyles as well as preventing diagnosis
- Information about the HIV testing process
- Option not to take the test.
- An opportunity to test at a later date should the client the test.
- Referral to HIV and AIDS related services such as nutrition, TB screening,

- CD4 count, opportunistic management and clinical staging.
- (Kartikeyan et al, 2007)

## **2.2 Pre-test Individual Counselling**

Pre- test counselling is the dialogue between the client and the counsellor that is aimed at discussing the HIV test and the possible implication of knowing one's HIV status. The quality and content of this session ought to be ensured because clients should be able to make informed decisions on whether or not to take the test. If they decide to take the test, they should be well- prepared for the result. Pre- test counselling provides an opportunity to help clients assess their personal risk and to know how to reduce that risk, even if they decide not to take the test.

(CDC, 1995)

Individual information should be available to all clients considering taking the HIV test in their language and the components of the individual information session should include the following:

- An assessment to determine if the information provided in the group session has been absorbed.
- Answering remaining questions, and seeking to clarify any misunderstanding.
- Discussion of specific issues for individual and assessment of individual risk, including enquiring whether a history of domestic violence exists.
- Discussion of risk reduction and the window period should the client test HIV negative.
- Discussion of prevention strategies including delayed sexual debut, abstinence and regular and correct use of condoms.
- Discussion of the way forward and management options including TB screening, clinical staging, pre antiretroviral management and healthy lifestyle, should the client test HIV positive
- Discussion on partner involvement and referral for testing.
- Discussion of the option to refuse testing.
- Obtaining of written or verbal informed consent for HIV testing.

- This information should be provided in the language of the client.  
(UNAIDS, 2000)

### **2.3 Post- Test Counselling**

This dialogue between the client and the counsellor intends to discuss the HIV test result. It aims to provide appropriate information, support and referral, and information on behaviour change that reduces the risk of becoming infected, even if the client is not infected. It also aims to reduce the risk of transmission of HIV to others, if the client is infected.

(Kartikeyan et al, 2007)

All clients, regardless of the outcome of the HIV test, should receive post- test counselling, and HIV negative clients should be offered post- test counselling that includes risk- reduction and be encouraged to repeat the test three months after the negative result to exclude the possibility of the window period. It is vital that HIV positive clients must only be given their test results and counselled post test about their positive status if the second confirmatory test is also positive.

Counselling clients who test HIV positive is about reducing the risk of transmission, ongoing positive living, healthy lifestyle and nutrition and referral to psychosocial support, (for example, support groups), preventative and medical services. After post- test counselling, referral of HIV positive clients for laboratory staging by CD4 count and clinical staging by a clinician trained in HIV and AIDS management, TB screening and pre antiretroviral (ART) management.

(Department of Health, Policy Guideline for HIV Counselling and Testing, 2009)

#### **Post- test counselling must take the following steps:**

- Give the results clearly.
- Deal with feelings arising from positive and negative results.
- Explain the meaning of a HIV test and the window period.
- Encourage the client to repeat the test after three months in order to exclude the possibility of the window period.

- Discuss the way forward including risk reduction and window period, and ongoing testing should the client test HIV negative.
- Discuss prevention strategies and safe sex practices including delayed sexual debut, abstinence and regular and correct use of condoms.
- Identify the client's immediate concerns and help with them
- Discuss what support the client has and what s/he needs.
- Discuss with whom the client may want to share the results.
- Where the client is in an abusive relationship, ask the client how s/he thinks the abusive partner will respond and refer the client for appropriate support.
- Discuss the importance of TB screening, clinical staging, CD4 count, pre-ART management and healthy lifestyle.
- Discuss the importance of partner testing.
- Encourage the client to ask questions.
- Provide information on and discuss a continuing healthy lifestyle.
- Provide information on future family planning choices/ options.

This information and follow- up counselling must be provided in the local language (or the language of choice) of the client/ patient. HIV counselling must ethical, based on human rights, conducted within a supportive environment and be provided where there is adequate health care infrastructure.

Department of Health, Policy Guideline for HIV Counselling and Testing (2009)

### **3     Research Problem**

The aim of this research paper is to determine the access to proper service delivery in health facilities with reference to HIV and AIDS Counselling.

In essence, the **research problem** to be discussed and analysed is:

**Is it easy to access proper service delivery in health facilities with reference to Voluntary Counselling and Testing/ HIV Counselling and Testing ?**

## **4     Literature Review**

The following information as an indication that VCT/ HCT among pregnant women can be utilized for every country that is facing the threat of HIV/ AIDS.

The research study that was done in India in 2005 shows that the HIV prevalence infection among pregnant women was more than 1% among antenatal clinic attendees in 95 districts. China's response was to introduced interventions which include policy of 100% condom use and most importantly, VCT.

(Kartikeyan, 2007)

VCT/ HCT is an important entry point for prevention of MTCT and must be available to all pregnant women. The benefits to a woman knowing her HIV status include earlier access to care for herself and her child, the ability to make informed choices about infant feeding options, the opportunity to terminate pregnancy where desired and legal, and the ability to make informed decisions about sexual practices and future fertility. VCT can also promote openness and acceptance of HIV as an important social issue.

(University of Kwazulu-Natal Implementation Manual for an Integrated Comprehensive Package of Care for PMTCT, 2006)

VCT/ HCT targets individuals, couples, families, and groups are the intended beneficiaries and the client should choose the person(s) who should be involved.

(Kartikeyan et al, 2007)

People solve their problems through a process of learning and experience, sometimes they may seek help from a family member, a friend or a respected colleague, but there are times when even these people cannot help, because the problem is too big, too new, too much of a secret or too strange. When this happens, ongoing counselling may be used as an intervention. The client/ patient often needs emotional support and an opportunity to express or open up their feelings and emotions, and they can only do this with the help of those who are better equipped to provide that kind of support.

Machedi (2006)

Van Rensburg (2004) discovered that in terms of the referral systems for these who provide HIV counselling and testing, it is important that clients/ patients are treated by appropriately trained staff and, on the other, the frontline health workers have support and back- up for decision making and are qualified for the service they render.

Voluntary Counselling and Testing is increasingly being recognized as a crucial component of effective strategies for HIV and AIDS prevention and care. If implemented properly, VCT has the potential of providing multiple benefits. In communities, VCT is as a means to create awareness, mobilize local responses and reduce denial, stigma and discrimination.

UNAIDS (2003)

#### **4.1 Benefits of VCT/ HCT**

- Encourages people to go for testing
- Early diagnosis is beneficial for prevention, care and treatment
- Allows for early coping with opportunistic infections and sexually transmitted infections ( STIS)
- Helps to normalize HIV and AIDS
- Helps to counter denial, fear and stigma
- Gives people a better chance to be cared for and supported
- Reduces mother to child transmission
- Helps change behaviour.

Jackson (2002)

#### **4.2 Couple Testing**

There are far more benefits to VCT when both partners in an ongoing relationship get tested and counselled together. If both partners are HIV negative or both are HIV positive, sharing this knowledge can help to either maintain a shared negative status, positively with HIV. If the couple have different HIV test results, couple counselling can make it easier to disclose test results and to introduce correct and consistent condom use into an ongoing relationship. While promoting couple testing, it is also important to ensure that each partner consents individually and privately to a test to



prevent any form of coercion.

UNAIDS (2002)

Utility for HIV infected clients is the strategy that enables early initiation of desirable behaviour changes to prevent transmission of infection and re-infection. It empowers the individual to cope with the diagnosis, take informed decisions about informing sexual partners, and this could not be possible if VCT/ HCT was not provided to clients.

(Kartikeyan et al, 2007)

The VCT services should comply with the protocols and national laws related to the provision of HIV related services.

(UNAIDS, 1999)

## **5      Research Methodology**

### **5.1    Research Design**

An attitude survey was done among the 150 clients/ patients at the following health facilities are identified as facility 1, facility 2, and facility 3 in Pretoria, South Africa, during September 2009 to determine whether access to HIV counselling could play a role in improving the uptake of Voluntary Counselling and Testing.

In addition to the 150 questionnaires for the clients/ patients, 15 were given to HIV lay counsellors to determine their capacity in terms of the service they provide to their clients/ patients.

Clients/ patients from facility 1, facility 2, and facility3 were chosen as population for this survey because they had been exposed to HIV counselling during their antenatal visits ranging between the months of May- August 2009. Here they gained first hand experience and knowledge of VCT during their pregnancy to promote the prevention of mother to child transmission (PMTCT). The HIV counselling is done by lay counsellors.

Christensen (2001) cites the notion that the survey method is a widely used descriptive research design that can be defined as a field of study in which an interview technique is used to gather data on a given state of affairs in a representative sample of the population.

Surveys are appropriate for gathering data regarding opinions and attitudes on the one hand, and behaviour on the other.

(Kerlinger, 1992)

According to Shiffman and Kanuk (1994), the survey is an accepted method of measuring both attitudes and behaviours.

Christensen (2001) added that ‘the descriptive research technique provides a description or a picture of a situation, and tries to describe the relationship that exists between variables’. In this case scenario, neither random assignment nor experimental manipulation of the variables are possible, therefore, a descriptive research approach, and more specifically, an ex- post- facto research design will be used in this study.

This is used because the variables are not under the experimenter’s control and are not subject to direct manipulation but must be chosen after the effect.

The weaknesses and limitations of the design will be taken into consideration during the interpretation of the results.

Other possible disadvantages of a survey include sampling error, time required, and constraints in the length of the survey.

(Christensen, 2001 & Theron, 2001)

## **5.2 Sampling**

Because the survey is optional to complete, each respondent in the sample of  $n= 165$  had the same probability of being part of the survey. All the responses were gathered over a one week period.

### 5.3 Data Collection

Respondents were notified via the VCT/HCT coordinator of the Tshwane region. The survey questionnaires were distributed by the coordinator then the respondents were randomly asked to complete the questionnaires.

At the beginning of the survey, respondents were assured that the survey was voluntary, anonymous and confidential. If they chose to proceed, they were asked to indicate their age group and the number of their clinic according to the coding that was used on questionnaires.

All respondents from these health facilities were asked to answer questions 1- 4 first, to ascertain how respondents perceived VCT/HCT counselling services during their recent ante- natal visit.

In doing this, they were asked to respond to the following questions:

- Whether VCT/HCT services are accessible for 24 hours in their respective health facilities,
- Whether HIV counselling was conducted in the language of their choice,
- Whether the counsellor secured a follow- up session,
- Whether the room provided adequate space for the counselling session.

Christensen (2001) defines closed ended questions as questions that require respondents to choose from a limited number of predetermined responses.

From question 5- question 14, all respondents were further asked to indicate the extent of their agreement or disagreement with the following statements listed below:

- The counsellor provided me with adequate health education during the session
- I did not have to wait for a long time before I received counselling,
- The counsellor gave me an opportunity to ask questions so I could get clarity on some things I did not know,
- We had a meaningful counselling session with the counsellor,
- The counselling room provided adequate privacy for the session,
- The counsellor assured confidentiality during the session,
- The counsellor was friendly when providing counselling

- It is easy to refer friends, colleagues and family members to the clinic,
- It was easy to identify where I could go for VCT/ HCT at the clinic,
- There is ongoing counselling services available at the clinic whether for HIV positive or HIV negative patients.

These types of questions were applicable and used to test attitudes regarding the stated research problem.

The reasons for this were that the survey was done after the whole testing at these three different facilities. Confidentiality and anonymity was guaranteed because of the following reasons:

- (i) No respondent was requested to provide her personal identification
- (ii) The VCT/HCT coordinator distributed questionnaires to respondents, some who attended the ante- natal clinic or post- natal: for those who had already given birth.

This was possible to do as nobody will know whether they are HIV positive or not, as both ante- natal and post- natal services are provided to all the women. As a result of this, the respondents in all three health facilities completed the survey.

Taking into account the high pregnancy rate in all the three areas including the feeder health facilities, the rate for pregnant women is 90%. Also, all the respondents who participated in the survey are aware that HIV counselling is compulsory for pregnant women visiting health facilities.

Therefore, the assumption is made that all the respondents were able to form a learned opinion of these VCT/HCT services, irrespective of whether they take the test after the HIV counselling or not.

In addition to the number of patients/ clients, 15 lay counsellors were notified via the VCT/ HCT coordinator of the Tshwane region. The questionnaires were distributed by the coordinator then the respondents were randomly asked to complete the questionnaires.

At the beginning of the survey respondents were assured that the survey was voluntary, anonymous and confidential. If they chose to proceed, they were asked to

indicate their health facility according to the coding that was used on questionnaires.

All respondents from these health facilities were asked to answer questions 1- 6 to ascertain how respondents perceived their daily VCT/HCT counselling experiences and skills when providing the service to their patients/ clients.

In doing this, they were asked to indicate the extent of their agreement or disagreement with the statements below:

- I feel I am adequately trained to do HIV counselling,
- I feel the number of clients I counsel per day are too many,
- Due to time constraints, I am unable to spend enough time on counselling,
- Sometimes counsellors at my clinic are expected to do the pricking for VCT instead of nurse,
- I do not have an opportunity to attend debriefing sessions in my workplace,
- I am presented with opportunities to attend refresher courses.

No respondent was requested to provide his/ her personal identification, so as to guarantee anonymity and confidentiality. This was possible to do as nobody will know which lay counsellor participated in the study. As a result of this, the respondents from in all three facilities completed the survey.

## **6. Statistical Analysis**

The statistical calculations were done with the assistance of Professor Herman Schoeman, a Clinical Biostatistician of the University of Limpopo (MEDUNSA).

- Frequency tables and graphs
- Likert scale
- Frequency counts and percentages.

The above mentioned analyses were done by using SAS, Release 9.1.3 a statistical analysis software programme.

### **6.1 Respondents Data (Clients)**

Three facilities, with 50 participants from each facility, and that makes up to 150 clients/ patients who were invited to participate in the survey, 150 (n=150) responded by completing the questionnaire. The number of respondents represented a return of 100% and will be shown later by means of tables and graphs.

In addition to the number of clients who participated in the survey, 5 lay counsellors from each facility (from the same facilities from which clients/ patients participated) were invited to participate in the survey, 15 (n=15) responded by completing the questionnaire. The number of respondents represented a return of 100%. This will be shown later by means of graphs tables.

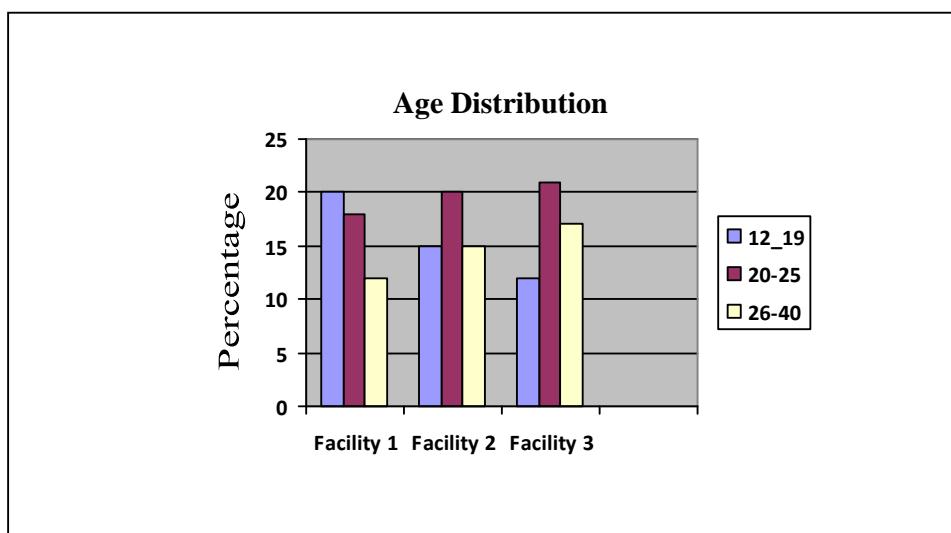
### **6.2 Respondent Data (Lay Counsellors)**

- Number of respondents invited to participate in the study : 15
- Actual number of respondents who participated in the study: 15
- Actual number of respondents as a percentage : 100%

### **6.3. Socio- demographic Data (Clients)**

The socio- demographic data is represented below according to their ages and their respective facilities.

(i) **Age Distribution**



The age distribution of all the participants (clients/ patients) for facility 1 n=50 is as follows:

- Below 19 years of age : 20
- Between 20- 25 years of age : 18
- Above 26 years of age : 12

The age distribution of all participants (clients/ patients) for facility 2 n=50 is as follows:

- Below 19 years of age : 15
- Between 20- 25 years of age : 20
- Above 26 years of age : 15

The age distribution of all participants (clients/ patients) for facility 3 n=50 is as follows:

- Below 19 years of age : 12
- Between 20- 25 years of age : 21
- Above 26 years of age : 17

The age distribution of the participants is representative of the different age groups in all the catchment areas of the facilities that are represented. The age of the antenatal attendees is fairly young, given the high rate of teenage pregnancy. It must be reiterated that the purpose of the study is not to measure the responses of the participants on the basis of their respective age groups.

It should also be noted that there is no gender distribution regarding respondents especially for the clients/ patients in the study since its main focus was on antenatal attendees, not because of gender exclusion or stereotypes.

#### **6.4 Socio- demographic Data (Lay Counsellors)**

There was no demographic data for lay counsellors as the only focus of the study was their counselling and daily experiences in their field. The statistical analysis of the data collected will be shown later by means of graphs and tables.

#### **6.5 Statistics Analysis: Graphs and Tables**

**Question 1:** VCT/HCT services are available for 24 hours a day

**Table 1**

Number (%) of patients							
Facility 1 (n=50)		Facility 2 (n=50)		Facility 3 (n=50)		Total (n=150)	
No	Yes	No	Yes	No	Yes	No	Yes
50 (100)		35 (70)	15 (30)	50 (100)		135 (90)	15 (10)

This table represents all the respondents to question 1 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof



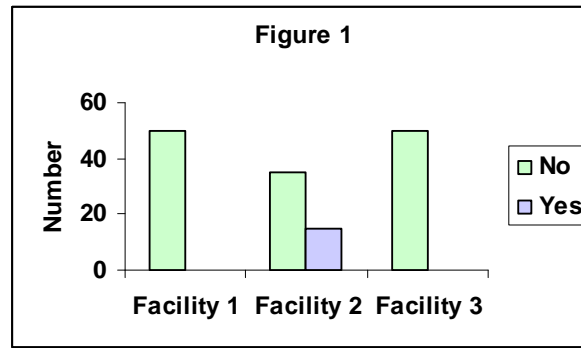


Figure 1 shows the number of facilities and the percentages of the respondents according to their responses to question 1.

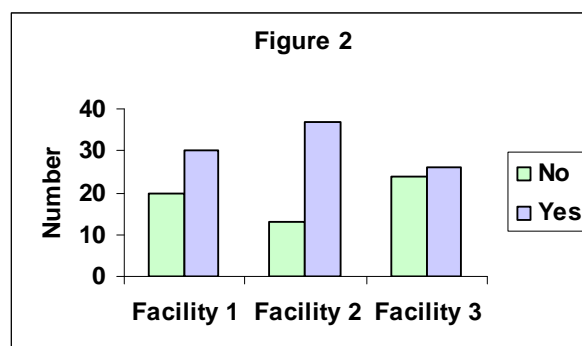
Hundred percent (100%) of respondents from facility 1 and facility 3, and 70% from facility 2, answered **no** to the statement in question 1 that VCT/ HCT services are available for 24 hours a day. The total percentage from all three facilities for the **no** answer is 90% and for the **yes** answer is 10%. The assumption made in this study is that some facilities may offer this type of a service voluntarily outside normal working hours depending on the situation at that moment.

**Question 2: Was HIV counselling conducted in the language of your choice?**

**Table 2**

Number (%) of patients							
Facility 1 (n=50)		Facility 2 (n=50)		Facility 3 (n=50)		Total (n=150)	
No	Yes	No	Yes	No	Yes	No	Yes
20 (40)	30 (60)	13 (26)	37 (74)	24 (48)	26 (52)	57 (38)	93 (62)

This table represents all the respondents to question 2 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.



**Figure 2**

Figure 2 shows the number of facilities and the percentages of the respondents according to their responses to question 2. Figure 2's data is as follows:

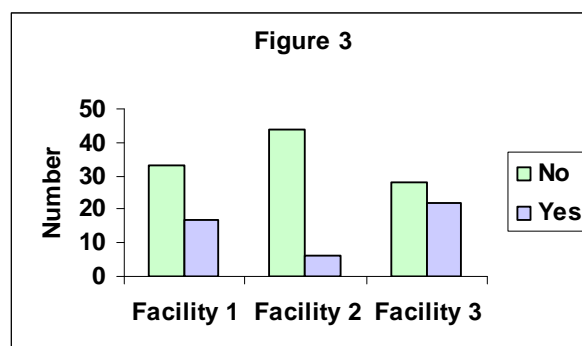
- Forty percent (40%) of the respondents from facility 1 answered **no**,
- Twenty six percent (26%) from facility 2 also answered **no** to the statement,
- Forty eight percent (48%) from facility 3 answered no to the statement, a considerable 62% from all three facilities answered **yes** to the statement that HIV counselling was conducted in the language of their choice. The assumption made in this study is that the majority of the respondents received HIV counselling in the language preferable to them. It is also assumed in the study that the 38% who gave a different view did not make the counsellor aware about their language preference.

**Question 3: Did the counsellor secure a follow-up session for you?**

**Table 3**

Number (%) of patients							
Facility 1 (n=50)		Facility 2 (n=50)		Facility 3 (n=50)		Total (n=150)	
No	Yes	No	Yes	No	Yes	No	Yes
33 (66)	17 (34)	44 (88)	6 (12)	28 (56)	22 (44)	105 (70)	45 (30)

This table represents all the respondents to question 3 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.



**Figure 3.**

Figure 3 shows the number of facilities and the percentages of the respondents according to their responses to question 3. Figure 3's data is as follows:

- Sixty six percent (66%) respondents from facility 1 answered **no**,
- Eighty eight percent (88%) from facility 2 answered **no**,
- Fifty six percent (56%) from facility 3 also answered **no** to the statement that the counsellor secured a follow- up session for them.

The assumption made in the study is that there is lack of follow- up counselling sessions in all three facilities for clients/ patients who might be in need of this vital service. This also poses a risk in the community because patients/ clients, whether they are HIV positive or not, they still need support to be able to make informed decisions in the future especially for newly diagnosed HIV positive patients/ clients. This service needs to be strengthen in all health facilities.

**Question 4: Did the room provide adequate space for the counselling session.**

**Table 4**

Number (%) of patients							
Facility 1 (n=50)		Facility 2 (n=50)		Facility 3 (n=50)		Total (n=150)	
No	Yes	No	Yes	No	Yes	No	Yes
48 (96)	2 (4)	45 (90)	5 (10)	50 (100)		143 (95)	7 (5)

This table represents all the respondents to question 4 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

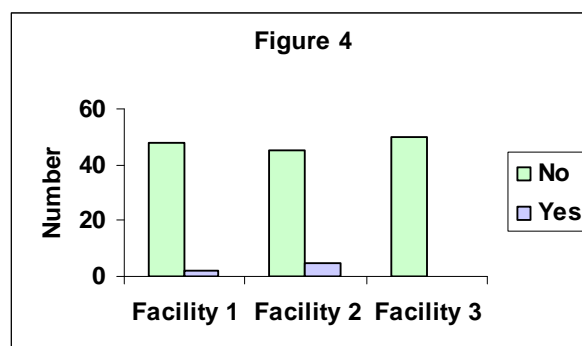


Figure 4 shows the number of facilities and the percentages of the respondents according to their responses to question 4. Figure 4's data is as follows:

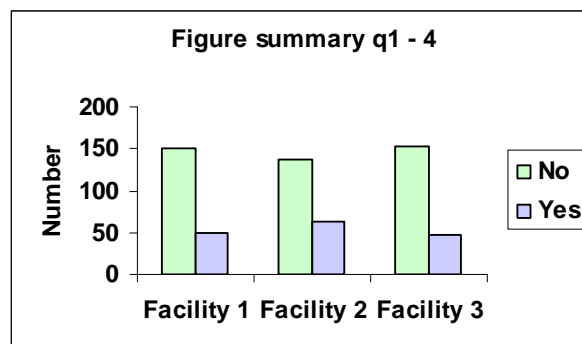
- Ninety six percent (96%) from facility 1 answered **no**,
- Ninety percent (90%) from facility 2 answered **no**,
- Hundred percent (100%) from facility 3 also answered **no** to the statement that the room provided adequate space for counselling session. The total number of the respondents who answered **no** is 95% and this gives the assumption that there lack of proper infrastructure for counselling in these three facilities. This is something that hinders the scaling of VCT/ HCT in health facilities and needs further investigation.

**Summary table for all the responses Q1 – Q4 from three facilities grouped together**

**Table 5**

Number (%) of patients							
Facility 1 (n=200)		Facility 2 (n=200)		Facility 3 (n=200)		Total (n=600)	
No	Yes	No	Yes	No	Yes	No	Yes
151 (76)	49 (24)	137 (68)	63 (32)	152 (76)	48 (24)	440 (73)	160 (27)

Table showing all the responses per percentage and numbers for the responses for question 1- question 4 from all three facilities.



The interpretation of the total number of responses from all three facilities for summary of questions 1-4 as shown above and it is as follows:

- Seventy six percent (76%) is the total number of all the **no** answers from facility 1, and 24% is the total number of all the **yes** answers.
- Sixty eight percent (68%) is the total number of all the **no** answers from facility 2, and 32% is the total number of all the **yes** answers.
- Seventy six percent (76%) is the total number of all the **no** answers from facility 3, and 24% is the total number of all the **yes** answers.

This makes up a grand- total number of 73% of all the **no** answers and 27% of all the **yes** answers from all three facilities grouped together.

The assumption made in this study shows that there is poor access to VCT/ HCT in all three facilities regarding the following aspects:

- Times in which VCT/ HCT services are provided,
- Follow- up sessions for clients who might need them,
- Space used for HIV counselling sessions.

**Question 5: The counsellor provided me with adequate health education during the session.**

**Table 6**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
43 (86)		7 (14)	31 (62)	1 (2)	18 (36)	8 (16)	4 (8)	38 (76)	82 (55)	5 (3)	63 (42)

This table represents all the respondents to question 5 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

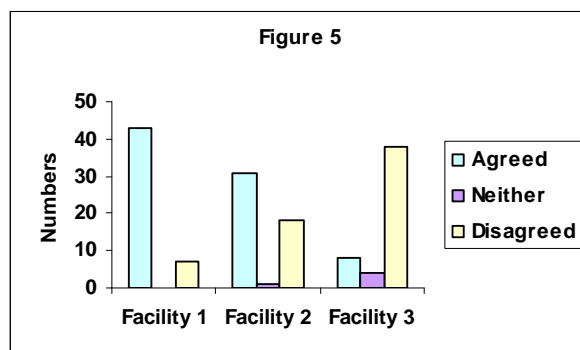


Figure 5 shows the number of facilities and the percentages of the respondents according to their responses to question 5. Figure 5's data is as follows:

- Eighty six percent (86%) of the respondents from facility 1 agreed with the statement,
- Sixty two percent (62%) from facility 2 also agreed and 2% neither agreed nor disagreed with the statement,
- Seventy six percent (76%) from facility 3 disagreed and 8% neither agreed nor disagreed with the statement that the counsellor provided them with adequate health education during the session. The grand- total for all who agreed is 55% and those who disagreed is 42%, and 3% neither agreed nor disagreed with the statement.

The assumption made in this study with regard to facility 3 is that there might be a problem of clients/ patients not being provided with this kind of information before they can decide whether to get tested or not and this needs further investigation.

**Question 6:** I did not have to wait for a long time before I received HIV counselling

**Table 7**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
2 (4)		48 (96)	7 (14)		43 (86)	2 (4)		48 (96)	11 (7)		139 (93)

This table represents all the respondents to question 6 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

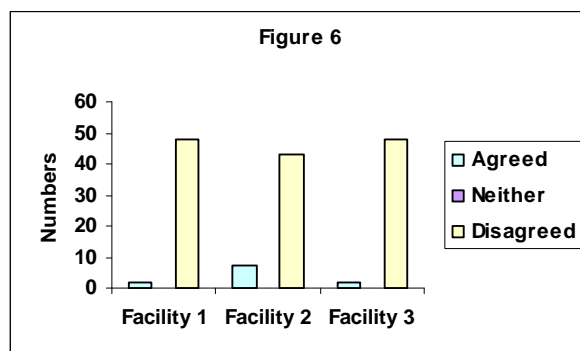


Figure 6 shows the number of facilities and the percentages of the respondents according to their responses to question 6. Figure 6's data is as follows:

- Four percent (4%) of the respondents from facility 1 agreed with the statement,
- Fourteen percent (14%) from facility 2 agreed with the statement,
- Four percent (4%) from facility 3 also agreed with the statement that they did not have to wait for a long time before they received HIV counselling.

The grand- total percentage for all those who agreed is 7% and for those who disagreed is 93%. The assumption made in this study is that all the respondents from all three facilities experienced a challenge of having to wait for a long time before they got HIV counselling. In future, the S.A. government, especially the Department of Health should look at ensuring that patients/ clients visiting health facilities for VCT/ HCT need to be attended within reasonable waiting period so that they are encouraged to visit these facilities even to refer other people as well.

People who visit facilities for VCT/ HCT are sometimes or always nervous to know their HIV status and the longer they are made to wait, the more likelihood that they can change their minds about taking the test.

**Question 7:** The counsellor gave me an opportunity to ask questions so I could get clarity on some things I did not know

**Table 8**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
37 (74)		13 (26)	37 (74)	2 (4)	11 (22)	4 (8)	2 (4)	44 (88)	78 (52)	4 (3)	68 (45)

This table represents all the respondents to question 7 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

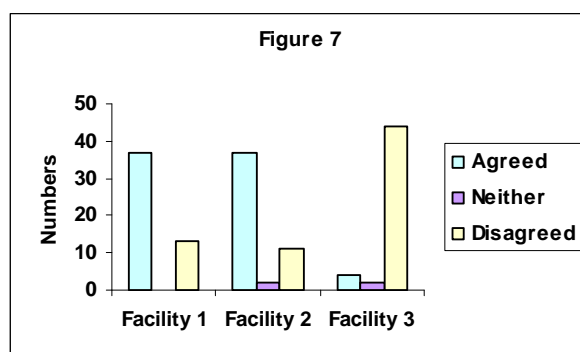


Figure 7 shows the number of facilities and the percentages of the respondents according to their responses to question 7. Figure 7's data is as follows:

- Seventy four percent (74%) of the respondents from facility 1 and facility 2 agreed with the statement and 4% from facility 2 neither agreed nor disagreed with the statement,
- Eighty eight percent (88%) of respondents from facility 3 disagreed, and 4% of respondents neither agreed nor disagreed with the statement that the counsellor gave them an opportunity to ask questions so they could get clarity on some things they did not know.

The grand- total number of the responses from all the three facilities in percentages, who agreed is 52%, who disagreed is 45%, and who neither agreed nor disagreed is 3%.



The assumption made in this study is that facilities 1 and 2 are doing a good job regarding this question while facility 3 , however, this means that there is poor access to this type of a service in facility 3.

**Question 8: We had a meaningful counselling session with the counsellor**

**Table 9**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
13 (26)	2 (4)	35 (70)	13 (26)	2 (4)	35 (70)	1 (2)	3 (6)	46 (92)	27 (18)	7 (5)	116 (77)

This table represents all the respondents to question 8 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

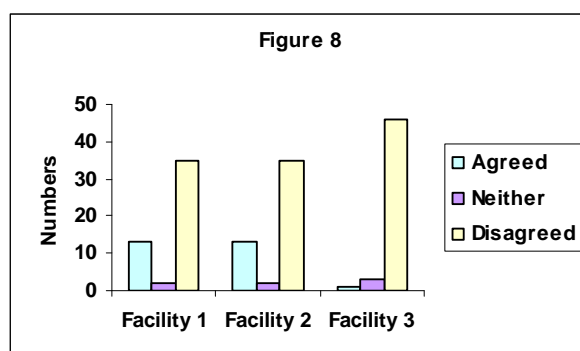


Figure 8 shows the number of facilities and the percentages of the respondents according to their responses to question 8. Figure 8's data is as follows:

- Twenty six percent (26%) of the respondents from facilities 1 and 2 agreed and 4% from both facilities neither agreed nor disagreed,
- Two percent (2%) from facility 3 of the respondents agreed and 6% neither agreed nor disagreed with the statement that they had a meaningful counselling session with the counsellor.

The grand- total number of the responses from all the three facilities in percentages, who agreed is 18%, who disagreed is 77%, and who neither agreed nor disagreed is 5%.

The assumption made in this study is that all respondents experienced a problem regarding the quality of time spent on counselling of patients/ clients.

**Question 9: The counselling room provided adequate privacy for the session**

**Table 10**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
2 (4)	3 (6)	45 (90)	8 (16)		42 (84)	1 (2)	3 (6)	46 (92)	11 (7)	6 (4)	133 (89)

This table represents all the respondents to question 9 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

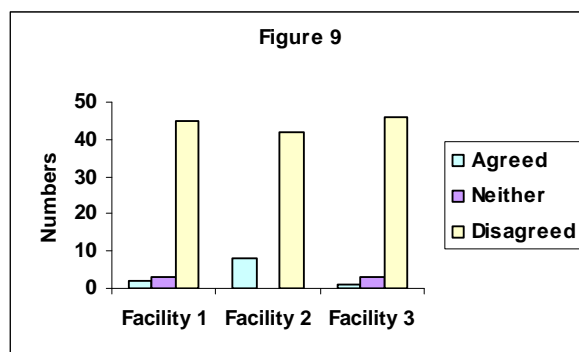


Figure 9 shows the number of facilities and the percentages of the respondents according to their responses to question 9. Figure 9's data is as follows:

- Four percent (4%) of the respondents from facility 1 agreed and 6% neither agreed nor disagreed with the statement,
- Sixteen percent (16%) of the respondents from facility 2 agreed,
- Two percent (2%) of the respondents from facility 3 also agreed and 6% neither agreed nor disagreed with the statement that the counselling room provided them with adequate privacy for counselling, while the grand- total for the disagreed answers is 89% and 7% for the agreed, and 4% for the neither agree nor disagree answers from all three facilities.

The assumption made in this study is that all three health facilities have a problem of adequate space for HIV counselling services.

**Question 10: The counsellor assured confidentiality during the session**

**Table 11**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
46 (92)		4 (8)	43 (86)	2 (4)	5 (10)		2 (4)	48 (96)	89 (59)	4 (3)	57 (38)

This table represents all the respondents to question 10 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

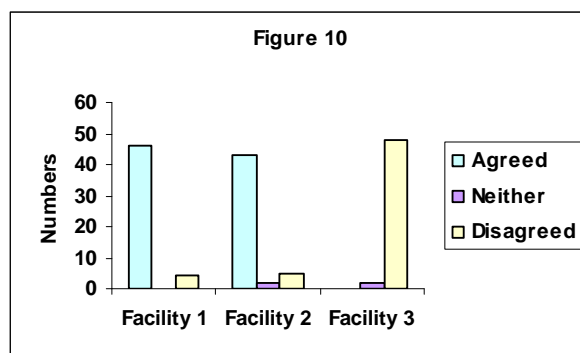


Figure 10 shows the number of facilities and the percentages of the respondents according to their responses to question 10. Figure 10's data is as follows:

- Ninety two percent (92%) of the respondents from facility 1, agreed with the statement,
- Eighty six percent (86%) respondents from facility 2 agreed and 4% neither agreed nor disagreed,
- Zero percent (0%) respondents from facility 3 agreed, and 96% from this facility disagreed and 4% neither agreed nor disagreed with the statement that the counsellor assured confidentiality during the session.

This amounts to a grand- total of 59% of respondents from all three facilities who agreed, and a grand- total of 38% who disagreed and 3% neither agreed nor disagreed. The assumption made is that there is a problem in facility 3 as opposed to facilities 1 and 2 where it looks like respondents were not assured confidentiality by the lay counsellor which may be of high risk for people's HIV status and their own personal information being shared with other people, and this needs to be further investigated.

**Question 11: The counsellor was friendly when providing counselling**

**Table 12**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
8 (16)	1 (2)	41 (82)	8 (16)	5 (10)	37 (74)	5 (10)	4 (8)	41 (82)	21 (14)	10 (7)	119 (79)

This table represents all the respondents to question 11 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

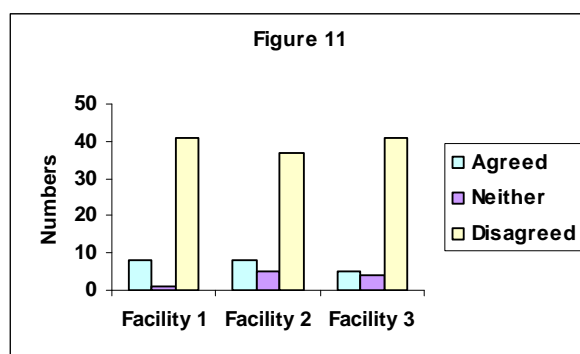


Figure 11 shows the number of facilities and the percentages of the respondents according to their responses to question 11. Figure 11's data is as follows:

- Sixteen percent (16%) respondents from facilities 1 and 2 agreed with the statement, and 2% from facility 1 and 10% from facility 2 neither agreed nor disagreed with the statement.
- Ten percent (10%) respondents from facility 3 also agreed and 8% neither agreed nor disagreed with the statement that the counsellor was friendly when providing counselling. However, the grand- total for all the responses from all three facilities show that 14% of respondents agreed and 79% of respondents disagreed, and 7% neither agreed nor disagreed with the statement.

The assumption made in the study is that in all three facilities respondents experienced the unfriendliness of the counsellor. This poses high risk to the uptake of VCT/ HCT services as a prevention strategy and an entry point to treatment, care and support.

**Question 12: It is easy to refer friends, colleagues and family members to the clinic**

**Table 13**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
7 (14)		43 (86)	1 (2)	8 (16)	41 (82)	1 (2)	1 (2)	48 (96)	9 (6)	9 (6)	132 (88)

This table represents all the respondents to question 12 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

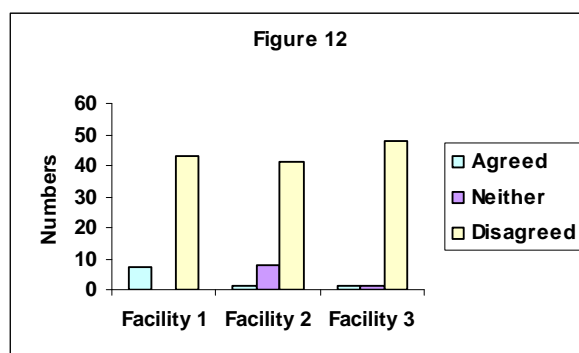


Figure 12 shows the number of facilities and the percentages of the respondents according to their responses to question 12. Figure 12's data is as follows:

- Fourteen percent (14%) respondents from facility 1 agreed with the statement,
- Two percent (2%) respondents from facilities 2 and 3 also agreed with the statement, 16% from facility 2, and 2% from facility 3 neither agreed nor disagreed with the statement that it is easy to refer friends, colleagues and family members to the clinic. The grand- total for all the responses from all three facilities show that 6% of respondents agreed and 88% of respondents disagreed and 6% of respondents neither agreed nor disagreed with the statement.

The assumption made in this study is that respondents did not feel comfortable to refer these category of people mentioned in the questionnaire. This is a problem because VCT/ HCT services are meant to assist people to access proper information, some of them being referred by either, friends, colleagues or family members in order to help in the scaling up of this service.

**Question 13: It was easy to identify where I could go for VCT/HCT at the clinic**

**Table 14**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=49)			Facility 3 (n=50)			Total (n=149)		
A	N	D	A	N	D	A	N	D	A	N	D
47 (94)		3 (6)	1 (2)	16 (33)	32 (65)	4 (8)	6 (12)	40 (80)	52 (35)	22 (15)	75 (50)

This table represents all the respondents to question 13 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

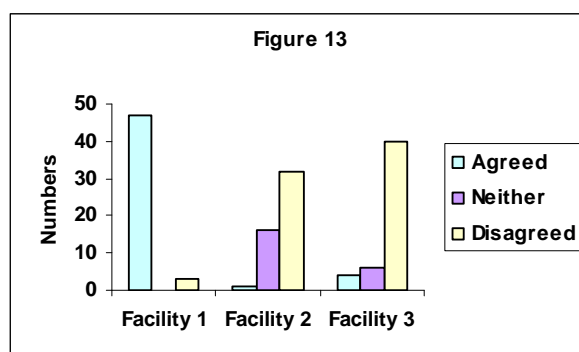


Figure 13 shows the number of facilities and the percentages of the respondents according to their responses to question 13. Figure 13's data is as follows:

- Ninety four percent (94%) of respondents from facility 1 agreed with the statement,
- Two percent (2%) of respondents from facility 2 agreed and 65% disagreed, 33% neither agreed nor disagreed,
- Eight percent (8%) of respondents from facility 3 also agreed, 80% disagreed and 12% neither agreed nor disagreed with the statement that it was easy to identify where they could go for VCT/ HCT at the clinic. The grand- total for all the responses from all three facilities show that 35%% of respondents agreed and 50% of respondents disagreed and 15% of respondents neither agreed nor disagreed with the statement.

The assumption made is that in facility 1, VCT/ HCT services are visible and appropriately marketed to the clients/ patients, while it is clear that there is a problem with facilities 2 and 3. The mechanisms used to inform patients/ clients who are targeted to scale up VCT/ HCT is very important so ensure accessibility.

**Question 14:** There are ongoing counselling services available at the clinic whether for HIV positive or HIV negative patients/ clients

**Table 15**

Number (%) of patients											
Facility 1 (n=50)			Facility 2 (n=50)			Facility 3 (n=50)			Total (n=150)		
A	N	D	A	N	D	A	N	D	A	N	D
4 (8)	2 (4)	44 (88)	13 (26)	11 (22)	26 (52)	1 (2)	9 (18)	40 (80)	18 (12)	22 (15)	110 (73)

This table represents all the respondents to question 14 and their responses in percentages and numbers from all the three health facilities where data was collected, including totals thereof.

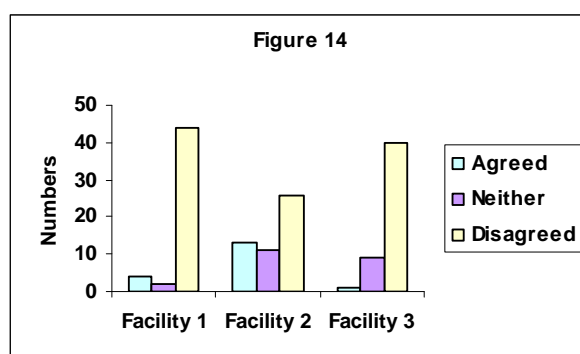


Figure 14 shows the number of facilities and the percentages of the respondents according to their responses to question 14. Figure 14's data is as follows:

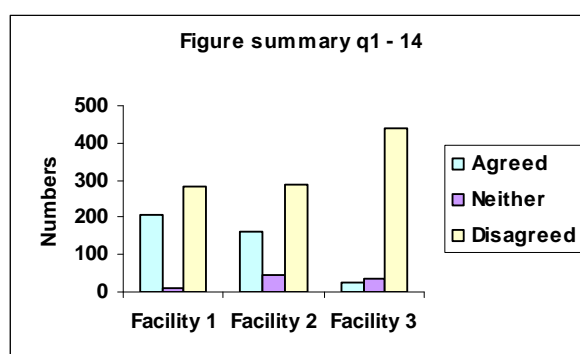
- Eight percent (8%) of respondents from facility 1 agreed and 88% disagreed, and 4% neither agreed nor disagreed with the statement,
- Twenty six percent (26%) of respondents from facility 2 agreed, 52% disagreed and 22% neither agreed nor disagreed,
- Two percent (2%) of respondents from facility 3 agreed and 80% disagreed and 18% neither agreed nor disagreed with the statement that there are ongoing counselling services available at the clinic whether for HIV positive or HIV negative patients/ clients.

**Summary table for all the responses Q5 – Q14 from three facilities grouped together**

**Table 16**

Number (%) of patients											
Facility 1 (n=500)			Facility 2 (n=499)			Facility 3 (n=500)			Total (n=1499)		
A	N	D	A	N	D	A	N	D	A	N	D
209 (42)	8 (24)	283 (57)	162 (32)	47 (9)	290 (58)	27 (52)	34 (7)	439 (88)	398 (27)	89 (6)	1012 (67)

Table showing all the responses per percentage and numbers for the responses for question 5- question 14 from all three facilities.



The interpretation of the total number of responses from all three facilities for summary of question 5- question 14 as shown above and it is as follows:

- Forty two percent (42%) is the total number of all the **agree**, 24% of **neither agree nor disagree** and 57% **disagree** answers from facility 1 grouped together.
- Thirty two percent (32%) is the total number of all the **agree**, 9% **all the neither agree nor disagree** answers and 58% of all the **disagree** answers from facility 2,
- Fifty two percent (52%) is the total number of all the **agree** answers from facility 3, and 7% is the total number of all the **neither agree nor disagree** and 88% is the total number of all the disagree answers.

This makes up a grand- total number of 27% of all the **agree** answers and 6% of all the **neither agree nor disagree** answers and 67% of all the **disagree** answers from all three facilities grouped together.

The assumption made in this study shows that in general, there is poor access to



VCT/ HCT in all three facilities regarding the following aspects:

- The lay counsellor being able to provide clients/ patients with adequate health education during the counselling session,
- The long waiting period in facilities,
- The lay counsellor being able to give clients/ patients an opportunity to ask questions and them providing appropriate answers,
- Lay counsellors being unable to spend reasonable amount of time on HIV counselling sessions,
- Inadequate room space for counselling sessions,
- Inability for lay counsellors to assure confidentiality to patients/ clients,
- The lay counsellor being unable to apply their empathy regarding being friendly during counselling sessions,
- Inability of the VCT/ HCT environment at health facilities to build trust in their patients/ clients so that it can be easy for them to refer others,
- The poor visibility of VCT/ HCT services in facilities,
- The lack of ongoing counselling sessions in health facilities.

### **Respondent Data ( Lay Counsellors)**

**Question 1: I feel I am adequately trained to do HIV counselling.**

**Table 17**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
5 (100)			3 (60)		2 (40)	1 (20)		4 (80)	9 (60)		6 (40)

This table represents all the respondents to question 1 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

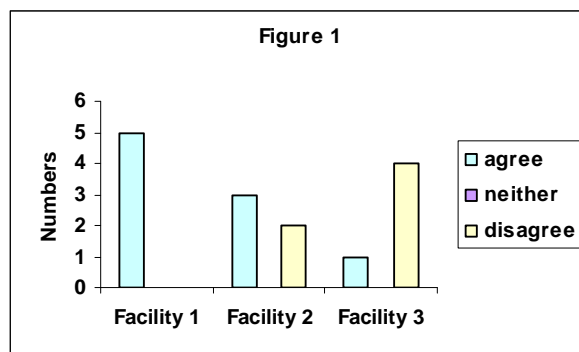


Figure representing percentages of responses from lay counsellors.

- Hundred percent (100%) from facility 1 agreed, 60% from facility 2, and 20% from facility 3.
- Forty percent (40%) from facility 2 disagreed with the statement.
- Eighty percent (80%) from facility 3 disagreed. A total percentage from three facilities show 60% of agreement and 40% disagreement with the statement.

The assumption made in this study is that lay counsellor from facilities 1 and 2 are adequately trained to do their job, but there is lack of adequate skills to do HIV counselling in facility 3. This needs to be addresses to ensure skilled people do the job.

**Question 2: I feel the number of clients I counsel per day is too many.**

**Table 18**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
5 (100)			5 (100)			5 (100)			15 (100)		

This table represents all the respondents to question 2 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

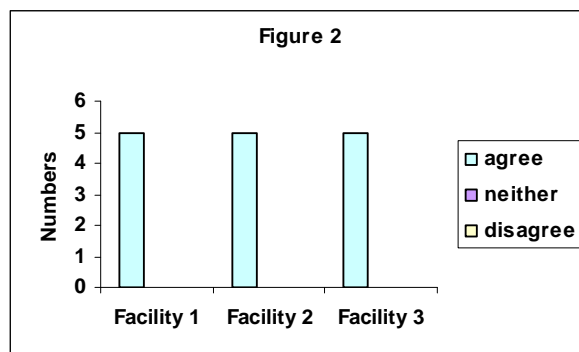


Figure representing percentages of responses from lay counsellors.

- One hundred percent (100%) from all three facilities agree with the statement that they feel the number of clients they counsel per day is too many.

The assumption made in this study show that lay counsellors have more people to counsel and this need to be looked into because it may lead to stress and burn- out.

**Question 3:** Due to time constraints, I am unable to spend enough time on counselling.

**Table 19**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
5 (100)			5 (100)			5 (100)			15 (100)		

This table represents all the respondents to question 3 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

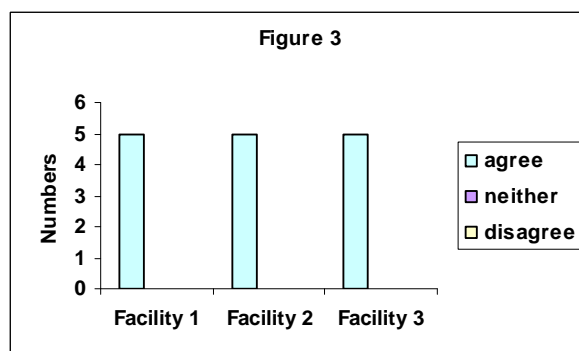


Figure representing percentages of responses from lay counsellors.

- One hundred percent (100%) of the respondents agreed with the statement that due to time constraints, lay counsellors are unable to spend enough time on counselling.

The assumption made in this study is that lay counsellors are unable to spend reasonable amount of time with patients/ clients during the counselling session because of the number of patients/ clients they attend to. This is a matter that needs serious consideration by the Department of Health as this compromises the quality of VCT/ HCT services in health facilities.

**Question 4: Sometimes counsellors at my clinic are expected to do the pricking for VCT instead of nurses.**

**Table 20**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
2 (40)		3 (60)	3 (60)		2 (40)	5 (100)			10 (67)		5 (33)

This table represents all the respondents to question 4 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

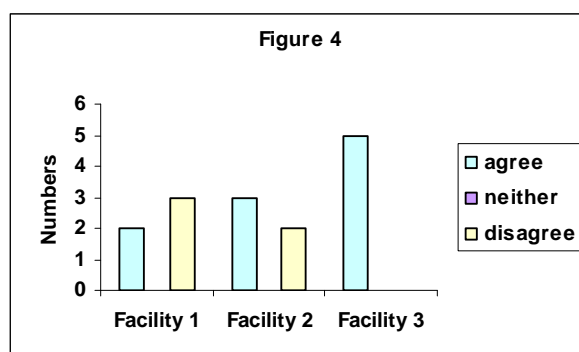


Figure representing percentages of responses from lay counsellors.

- Forty percent (40%) from facility 1 agreed to the statement that sometimes counsellors at their clinic are expected to do the pricking for VCT/ HCT instead of nurses.
- Sixty percent (60%) from facility 2 agreed, while 40% disagreed.
- Hundred percent (100%) from facility 3 agreed.
- Total percentage of 67% from three facilities agreed and 33% disagreed.

The assumption made in this study is that some facilities have done task- shifting in order to allow their lay counsellors to learn and do more than others do in their facilities. Maybe this is due to capacity- building of some kind.

**Question 5: I do not have an opportunity to attend debriefing sessions in my work place.**

**Table 21**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
4 (80)		1 (20)	5 (100)			5 (100)			14 (93)		1 (7)

This table represents all the respondents to question 5 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

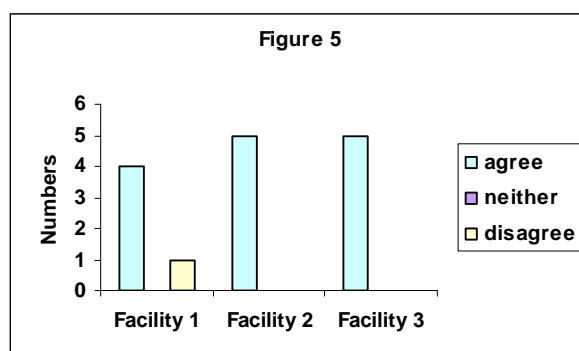


Figure representing percentages of responses from lay counsellors.

- Eighty percent (80%) from facility 1 agreed that they do not have an opportunity to attend debriefing sessions in their workplaces.
- Hundred percent (100%) from facility 1 and 2.
- This shows a total of 93% respondents who agreed and 7% respondents who disagreed.

The assumption made in this study is that lay counsellors do not have an opportunity to attend debriefing sessions which also not good given the kind of the job that they do. Debriefing sessions are important so that lay counsellors are able to learn and share challenges and successes with their colleagues.

**Question 6: I am presented with opportunities to attend refresher courses**

**Table 22**

Number (%) of patients											
Facility 1 (N=5)			Facility 2 (N=5)			Facility 3 (N=5)			Total (N=15)		
A	N	D	A	N	D	A	N	D	A	N	D
1 (80)		4 (80)	2 (40)		3 (60)	1 (20)		4 (80)	4 (27)		11 (73)

This table represents all the respondents to question 5 and their responses in percentages from all the three health facilities where data was collected, including totals thereof.

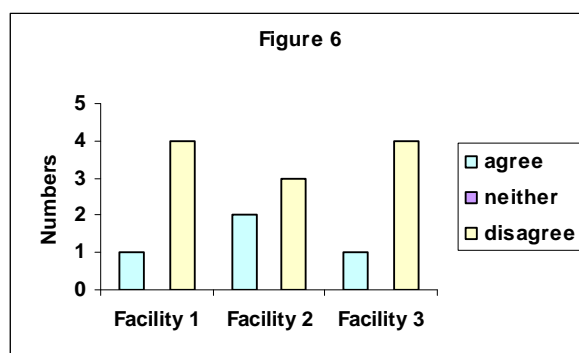


Figure representing percentages of responses from lay counsellors.

- Twenty percent (20%) from facility 1 agreed, while 80% disagreed with the statement that they are presented with opportunities to attend refresher courses,
- Forty percent (40%) from facility 2 agreed, while 60% disagreed.
- Twenty percent (20%) from facility 3 agreed, while 80% disagreed.
- This gives a total of 27% of agreed and 73% of disagreed responses.

The assumption that is made in this study is that in all three facilities lay counsellors do n have an opportunity to be sent for any refresher courses. This also impacts negatively on quality service delivery for VCT/ HCT. It is important that people who work with all HIV/ AIDS related issues are always up- to- date current information as this is an evolving disease.

**Summary table for all the responses Q1 – Q6 from three facilities grouped together**

**Table 23**

Number (%) of patients											
Facility 1 (N=30)			Facility 2 (N=30)			Facility 3 (N=30)			Total (N=90)		
A	N	D	A	N	D	A	N	D	A	N	D
22 (73)		8 (27)	23 (77)		7 (23)	22 (73)		8 (27)	67 (74)		23 (26)

This table represents a percentage of all summary responses from lay counsellors in all the three facilities.

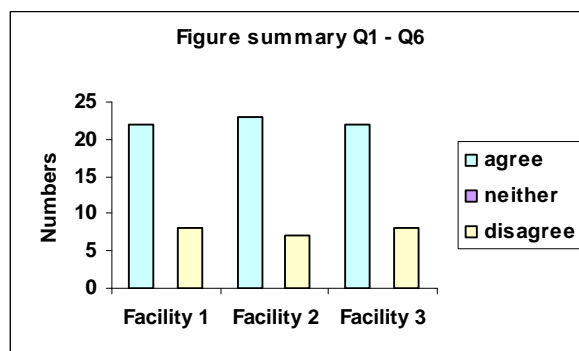


Figure summary representing question 1- question 6 from lay counsellors.

- Seventy three percent (73%) from facility 1 agreed, while 27% disagreed with the statement.
- Twenty seven percent (77%) from facility 2 agreed, while 23% disagreed.
- Seventy three percent (73%) from facility 3 agreed, while 27% disagreed.

The grand- total number of the responses from all three facilities are as follows:

- Seventy four percent (74%) of all the **agree** responses and 26% of **disagree** responses grouped together.

The assumption that is made in this study is that there is in general, poor quality of VCT/ HCT provided by lay counsellors in all three facilities especially regarding the following aspects:

- The large number of clients they provide counselling to,
- Unavailability of reasonable time to spend enough time with clients/ patients,
- Task- shifting to accommodate clients/ patients load.

- Lack of opportunities to attend debriefing sessions and refresher courses.



## **7. Findings**

### **7.1 Findings Clients/ Patients Data**

Seventy four (74%) of respondents, 150 (n=150) (clients/ patients) from all three facilities across all age groups had said no to all the first four questions, i.e. question1- question 4 while 26% of the same category responded with yes. This shows that there is poor access to VCT/ HCT services in all three facilities regarding the following aspects:

- Opening and closing times,
- Access to information in the language preferable to the client/ patient,
- Unavailability of follow- up sessions for clients/ patients who would like to consult further,
- Inadequate infrastructure in terms of the counselling space.

In addition to this information, regarding information provided by respondents from question 5- question 14, the total responses is as follows:

- Twenty seven percent (27%) of respondents (clients/ patients) from all three facilities across all age groups agreed with the statements, while 67% disagreed with statements. This shows that there are challenges from all three facilities and they are listed below as follows:
- Challenges in terms of the lay counsellor having to provide adequate health education ,
- The long waiting period before clients/ patients could receive HIV/ HCT counselling,
- The lay counsellor having to provide clients with an opportunity to ask questions and given clarity where applicable,
- Having provided with meaningful counselling sessions,
- Lack of privacy because the nature of counselling rooms used for HIV counselling,
- Issues pertaining to confidentiality,
- Clients not confident to refer their family, friend or colleague,
- Inability for the identification of VCT/ HCT services at the facility,

- Lack of ongoing counselling for both HIV positive/ negative clients/ patients.

## **7.2 Findings and Recommendations :Lay Counsellors' Data**

The following is data collected from 15 lay counsellors (n=15) from all three health facilities.

Seventy four percent (74%) agreed, while 26% disagreed with the statements about their HIV counselling experiences. The following is an example of what came out of this research paper regarding lay counsellors' daily counselling experiences:

- Lay counsellors do not agree that they are adequately trained to do HIV counselling.
- They feel they see more clients per day,
- Time constraints do not allow them to spend enough time during counselling,
- Lay counsellors are sometimes expected to do the pricking for VCT/ HCT instead of the role being played by nurses,
- Lay counsellors do not have an opportunity to attend debriefing sessions,
- Lay counsellors are not presented with opportunities to attend refresher courses.
- At the end of the lay counsellors questionnaire, there is a part where they indicated the training that they have so as to carry out the responsibility of their core function. What lay counsellors indicated was the fact 100% of the surveyed ones, was trained on peer education and as well as HIV and AIDS counselling. However, 96% indicated that there are no refresher courses for them to keep them up- to- date with current HIV related issues. In addition, 80% cited the issue of workload that result to not having enough time to spend with clients, being unable to do ongoing counselling.

## **8. Recommendations**

As a result of this research paper findings for the following recommendations for future purposes are as follows:

It is important that there is an understanding of baseline needs assessments in the community prior to setting up a service that provides information on whether VCT/HCT is wanted and this information can help to ensure that services are set up in appropriate areas, not merely on the basis of HIV prevalence. For example, the currently available VCT/HCT services are available in medical set- ups where this element hinders the proper marketing of VCT/HCT.

### **8.1 Availability of Adequately Trained Personnel**

The quality of service delivery is expected to be determined by the adequacy of staffing levels as well as all the technical and professional capacities of staff employed in VCT/HCT facilities. Also, perceptions of the lack of confidentiality in VCT/HCT facilities influences low VCT/HCT uptake in health facilities. There is need for the government to develop a platform for cooperation with civil society and CBOs, NGOs whereby the government will create a facilitating environment by providing technical and financial support so that these organizations can be able to provide much needed services. This will enable the expansion of service delivery and increase access to VCT/HCT. This can reduce stigma and discrimination of HIV and AIDS.

### **8.2 Organisational Support For Staff**

If given opportunities, lay counsellors have good potential since they are from communities themselves given the high level of stigma attached to HIV/ AIDS. Organisational support should be integrated to the organizational culture, whereby managers and supervisors ensure that every effort is made for the provision of a

supportive working environment, that also include debriefing sessions to avoid emotional stress and so as to ensure a good network system.

The Department of Health, should take note and address the detrimental effects of too heavy a workload on staff at all levels, but specifically the lay counsellors, and should allocate a manageable number of clients/ patients on every counsellor per day.

Frequent meetings are also important so as to identify challenges and address them immediately if possible. The involvement of staff by management in decision- making is important. Supervision, mentoring and coaching for lay counsellors is important as it provides a good environment for learning. Managers and supervisors should guide the process of case management and ensure that HIV counselling is helpful and not harmful.

Lay counsellors should always be provided with continuing/ training education, refresher courses, updates and workshops to upgrade their skills. These will help them deliver quality service to their clients/patients.

### **8.3 Monitoring And Evaluation**

Monitoring and evaluation is a necessary component of the implementation and management of the VCT/HCT programmes, ensuring that the resources going into a programme are being utilized, services are being accessed, activities are occurring in an efficient and guided manner, and the expected results are being achieved. This is for improving service quality and thus obtaining the maximum health benefit for the population served.

Monitoring is the routine tracking of service and programme performance using input, process and outcome information, collected on a regular and ongoing basis. This includes VCT/HCT programme tools such as registers, regular reporting systems and template (for example, District Health Information Systems) as well as health facility support visits, client surveys and to some extent population based surveys.

(National Department of Health HCT Guideline 2009)

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## **ADDENDUM A**



### **HIV counselling Questionnaire**

This questionnaire is used to determine people's perceptions on the quality of HIV counselling in the health facility. This questionnaire is meant for those who have an experience of VCT/HCT in the health facility

Please complete the form, it is completely voluntary, anonymous and confidential. Your cooperation is highly appreciated.

<b>Please indicate your:</b>					
<b>GENDER</b>	<b>Male</b>		<b>Female</b>		
<b>AGE GROUP</b>	<b>12-19</b>		<b>20-25</b>		<b>26-40</b>

<b>Place a tick in the appropriate column</b>		
<b>1. VCT/HCT services are available 24 hours a day</b>	<b>NO</b>	<b>YES</b>
<b>2. Was HIV counselling conducted in the language of your choice?</b>		
<b>3. Did the counsellor secure a follow- up session for you?</b>		
<b>4. Did the room provide adequate space for the counselling session?</b>		

<b>Please indicate the extent of your agreement or disagreement with the statement below. Do this by placing a tick in the appropriate column.</b>	<b>strongly agree</b>	<b>agree</b>	<b>neither agree nor disagree</b>	<b>disagree</b>	<b>strongly disagree</b>
<b>5. The counsellor provided me with adequate health education during the session</b>					
<b>6. I did not have to wait for a long time before I received HIV counselling</b>					
<b>7. The counsellor gave me an opportunity to ask questions so I could get clarity on some things I did not know</b>					
<b>8. We had a meaningful counselling session with the counsellor</b>					
<b>9. The counselling room provided adequate privacy for the session</b>					
<b>10. The counsellor assured confidentiality during the session</b>					
<b>11. The counsellor was friendly when providing counselling</b>					
<b>12. It is easy to refer friends, colleagues and family members to the clinic</b>					
<b>13. It was easy to identify where I could go for VCT/HCT at the clinic</b>					
<b>14. There is ongoing counselling services available at the clinic whether for HIV positive or HIV negative patients</b>					

Please provide any additional information/ experience that you would like to share with us regarding the services that you have experienced at the clinic. At this point, we would like to thank you for your time to complete the form.

### **QUESTIONNAIRE FOR HIV COUNSELLORS**

**Please indicate the name of your health facility in the spaces provided:**

<b>FACILITY 1</b>	<b>FACILITY 2</b>		<b>FACILITY 3</b>	

### **PLEASE TELL US ABOUT YOUR HIV COUNSELLING EXPERIENCE:**

Please indicate the extent of your agreement or disagreement with the statement below. Do this by placing a tick in the appropriate column.	<b>strongly agree</b>	<b>agree</b>	<b>neither agree nor disagree</b>	<b>disagree</b>	<b>Strongly disagree</b>
1. I feel I am adequately trained to do HIV counselling					
2. I feel the number of clients I counsel per day is too many					
3. Due to time constraints, I am unable to spend enough time on counselling					
4. Sometimes counsellors at my clinic are expected to do the pricking for VCT instead of nurses					
5. I do not have an opportunity to attend debriefing sessions in my workplace					
6. I am presented with opportunities to attend refresher courses					

7. List any training programmes you are trained on

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Please feel free to add any comments regarding challenges and successes of your duties. We thank you for your time to complete the form.

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